H. Mental Health

Mental health is one of the 11 health priorities of *Healthiest Wisconsin 2010* and is a major public health issue both in Wisconsin and our nation. In 2001, in both the U.S. and in Wisconsin, 13% of the population reported that they had poor mental health.[1]

In general, the prevalence of mental disorders in racial/ethnic minority groups nationwide does not significantly differ from prevalence rates for the majority population. However, racial and ethnic minorities are overrepresented in high-need populations where the rates of mental illness tend to be much higher (e.g., the homeless, incarcerated, or children in out-of-home placement). Also, cultural and social factors influence mental health and mental health access in racial and ethnic minority groups. For example, African Americans are more likely than whites to be misdiagnosed with schizophrenia.[2]

Stressful events that adversely affect mental health and access to mental healthcare in minority populations include racism, discrimination, poverty, and lack of culturally competent care.[2] Racial and ethnic minorities are much more likely to be poor than white majority populations. Living in poverty is the most prominent and measurable factor affecting the rates of mental illness, and persons with low socioeconomic status are more likely to have a mental disorder than persons with a high socioeconomic status.[2]

The mental health field is plagued by disparities in the availability of and access to its services, particularly related to a person's financial status. According to a Surgeon General's report on mental health, "Formidable financial barriers block needed mental healthcare from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance."[3]

Cultural and access barriers related to mistrust, where care is or can be obtained, and language and cultural barriers particularly affect mental health in populations of color. Racial/ethnic minorities are less likely to receive needed mental healthcare due to mistrust of mental health services and clinical environments that are incompatible with the cultures of the people served which deter minorities from seeking treatment. Furthermore, racial/ethnic minorities receive a disproportionate share of mental health treatment from "safety net" providers and in emergency rooms or institutionalized settings when symptoms are more severe. Mental healthcare for racial/ethnic minorities is further complicated because of the lack of English proficiency and lack of providers with appropriate linguistic and cultural competence.[2]

Depression

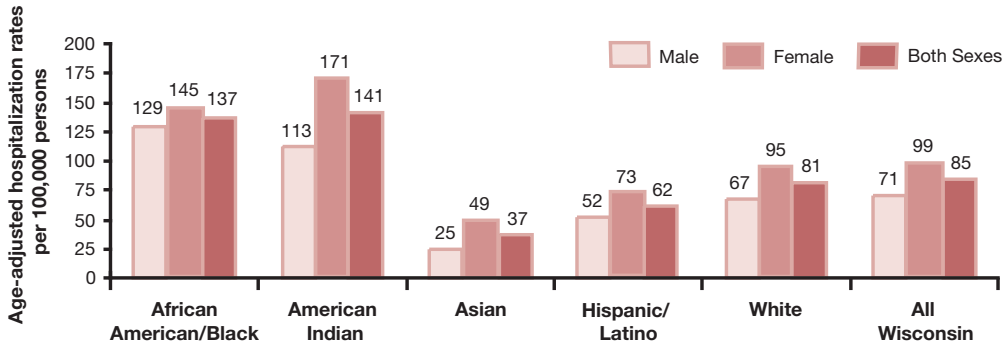
Depression is one of the most commonly diagnosed major psychiatric disorders. Women have approximately a 2 times greater rate of major depression than men, and lifetime incidence of a major depressive diagnosis is 20% in women and 12% in men. Significant racial/ethnic differences in depression have not been elicited.

Studies suggest a high prevalence of affective disorders among patients seeking medical attention in the office setting. The prevalence of depression is as high as 10% in patients observed in a medical setting; therefore primary care providers should strongly consider the presence of depression in their patients. While many effective treatments are available, depression is often underdiagnosed and undertreated.

Hospitalization for depression does not necessarily document the prevalence of depression in the general population. Higher or lower inpatient hospitalization rates for mental illness among minorities may be due to social and cultural factors or limited access to or utilization of outpatient primary care and mental health services.[2]

- African Americans and American Indians in Wisconsin had the highest rates of inpatient hospitalization for depression. The rates for African Americans (137 per 100,000) and American Indians (141 per 100,000) were both 1.6 times higher than in the total Wisconsin population (85 per 100,000).
- Overall, women are more likely than men to have a diagnosis of depression, and more Wisconsin women than men were hospitalized for depression, which mirrors national trends. American Indian women had the highest overall rates of hospitalization for depression in Wisconsin—1.8 times greater than the rate for white women.
- Asians were least likely to be hospitalized for depression, but this may not accurately illustrate the prevalence of depression in various Asian communities. Refugees from Southeast Asian countries and other overseas refugees are at risk for post-traumatic stress disorder (PTSD) as a result of war trauma, terror, or other traumatic circumstances preceding their immigration to the United States. Displacement from their homeland, isolation, and language barriers can affect mental health status.[2]

Figure 61: Average annual age-adjusted depression hospitalization rates by race/ethnicity and sex, Wisconsin, 1996–2000



Source: Wisconsin inpatient discharge data, Wisconsin Department of Health and Family Services, Bureau of Health Information. Graph prepared by the Wisconsin Public Health and Health Policy Institute, University of Wisconsin-Madison.

Note: Rates are age-adjusted to the U.S. year 2000 standard population.

Schizophrenia

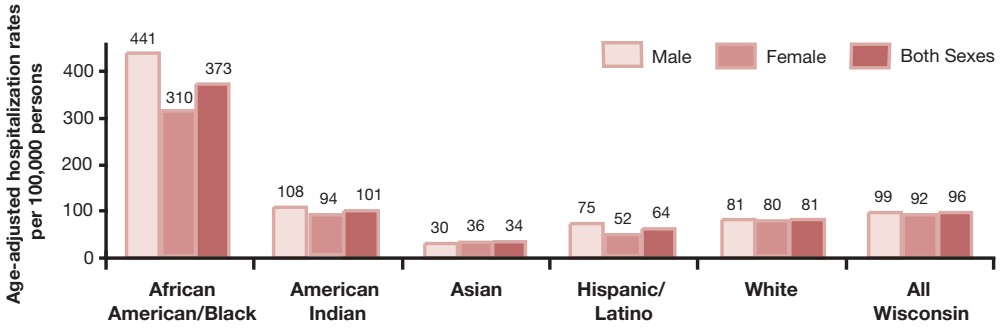
Schizophrenia is a chronic debilitating psychiatric disorder. The prevalence of schizophrenia is approximately 1% worldwide. Despite extensive research, it is not a well-understood condition and probably consists of several separate illnesses. Symptoms include disturbances in thought (or cognition), affect, perceptions, and difficulties in relationships with others. The hallmark symptom of schizophrenia is the experience of auditory hallucinations. However, impaired information processing is probably the most harmful symptom. Patients with schizophrenia usually have lower rates of employment, marriage, and independent living than other people.

The causes of schizophrenia are not known. Widespread research is focusing on abnormalities in brain development. These could be due to either genetic or perinatal factors.[4] Research indicates the risk of schizophrenia is elevated in biological relatives of patients who have schizophrenia but not in adopted relatives. The risk of schizophrenia in first-degree relatives of people with schizophrenia is 10%. If both parents are schizophrenic, the risk of schizophrenia in their child is 40%. The concordance rate (of both twins having the condition) for schizophrenia is about 10% for fraternal twins and 40% to 50% for identical twins.

No known racial differences exist in the prevalence of schizophrenia. However, some research indicates that schizophrenia is diagnosed more frequently in African Americans than in whites. One of the reasons for the difference may be social and cultural factors (e.g., clinician stereotyping and misunderstanding of cultural differences in symptom presentation)[5] and potential misdiagnosis of other psychiatric conditions. Also, African Americans may be overrepresented in inpatient settings for treatment of mental illness partly due to delay in seeking treatment until symptoms are more severe.[2]

- There was a significant difference in hospitalizations due to schizophrenia between African Americans and other racial or ethnic groups in the state. The rate in African Americans far exceeded other racial or ethnic groups.
- African American males were hospitalized with a principal diagnosis of schizophrenia at a rate of 441 per 100,000 population—over 5 times higher than white males (81 per 100,000). A disparity also existed for African American females who had an annual hospitalization rate for schizophrenia of 310 per 100,000 population; this was 3.9 times the state rate for white females.

Figure 62: Average annual age-adjusted schizophrenia-related hospitalization rates by race/ethnicity and sex, Wisconsin, 1996–2000



Source: Wisconsin inpatient discharge data, Wisconsin Department of Health and Family Services, Bureau of Health Information. Graph prepared by the Wisconsin Public Health and Health Policy Institute, University of Wisconsin-Madison.

Notes: Based on principal discharge diagnosis of schizophrenia ICD-9-CM: 295.
Rates are age-adjusted to the U.S. year 2000 standard population.

Bipolar Disorder

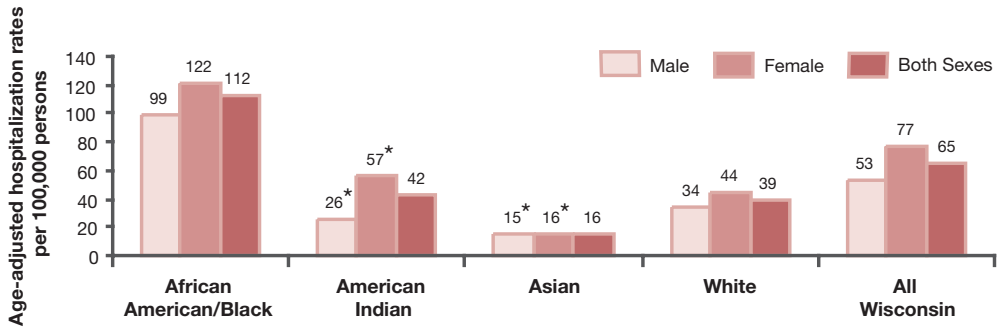
Bipolar disease (or manic-depressive illness) represents a severe and persistent mental illness. It can fluctuate from milder to severe forms. In its severe form, bipolar disease is characterized by periods of deep, prolonged, and profound depression that alternate with periods of excessively elevated and/or irritable mood known as mania. The symptoms of mania include a decreased need for sleep, pressured speech, increased libido, reckless behavior without regard for consequences, grandiosity, and severe thought disturbances, which may or may not include psychosis. Between these highs and lows, patients usually experience periods of higher functionality and can lead a productive life.

The lifelong prevalence rate of bipolar disorder in the United States is 1% to 1.6%. It occurs in two primary forms: Bipolar I (BPI) is the more severe form, and Bipolar II (BPII) tends to be less severe. The two types of disorders differ in adult populations, with approximately 0.8% having BPI and 0.5% having BPII. In some reviews of the topic, up to 20% of persons with BPI have committed suicide. The good news is that improved treatments are available.

Historically, bipolar disease was thought to affect more whites than other races and a genetic link has been established in some families. However, more progressive thinking suggests that comparable rates of this disease may occur in other racial and ethnic groups, but is underdiagnosed. It is thought that some of the observed racial differentials in schizophrenia may have resulted in the underdiagnosis of this more treatable condition of bipolar disorder.[2]

- During 1996–2000 in Wisconsin, African Americans had the highest rate of inpatient hospitalizations with a diagnosis of bipolar disorder. It does not follow that African Americans had a higher prevalence of bipolar disorder than other racial/ethnic groups.

Figure 63: Average annual age-adjusted bipolar hospitalization rates by race/ethnicity and sex, Wisconsin, 1996–2000



Source: Wisconsin inpatient discharge data, Wisconsin Department of Health and Family Services, Bureau of Health Information. Graph prepared by the Wisconsin Public Health and Health Policy Institute, University of Wisconsin-Madison.

Notes: Based on principal discharge diagnosis of bipolar disease ICD-9-CM: 296.4–296.7.

Rates are age-adjusted to the U.S. year 2000 standard population.

*Rate is based on six or less hospitalizations per year.

Alcohol and Other Drug Use

Alcohol and other drug use and addiction is a significant health, social, public safety, and economic problem; it is one of the 11 health priorities of *Healthiest Wisconsin 2010*. Alcohol or other drug abuse and dependency are illnesses that impair the performance of vital bodily functions and can cause significant disability and early death. Alcohol or other drug disorders can result in family discord, reduced productivity or employment, delinquency, crime, and financial problems.[6]

Of the more than 2 million deaths each year in the U.S., one in four is attributable to alcohol, tobacco, and illicit drug use. Each year in Wisconsin there are 1,300 deaths, 17,000 hospitalizations, 8,500 traffic crashes, and 90,000 arrests attributable to alcohol and other drug abuse. The economic impact in Wisconsin each year attributed to alcohol and other drug use is estimated at over $4.6 billion dollars.[7]

Factors that influence alcohol and other drug use patterns and problems include genetics, age, social norms and laws, social involvement, economics, mental health, emotional pain or trauma, self-esteem, and environment. Alcohol and other drug abuse is not caused by race.[8]

Reported alcohol use among U.S. American Indians varies between 10% to 30%. Some studies suggest a genetic influence for some cases of dependence.[9] However, other literature emphasizes the influence of age, social norms, environment, and low socioeconomic status on the rates of alcohol use in American Indian populations.[10] Many studies report lower rates of alcohol use among Asian/Pacific Islanders. However, recent evidence suggests that consumption may be increasing in Asian/Pacific Islander populations.[10]

Risk Factors

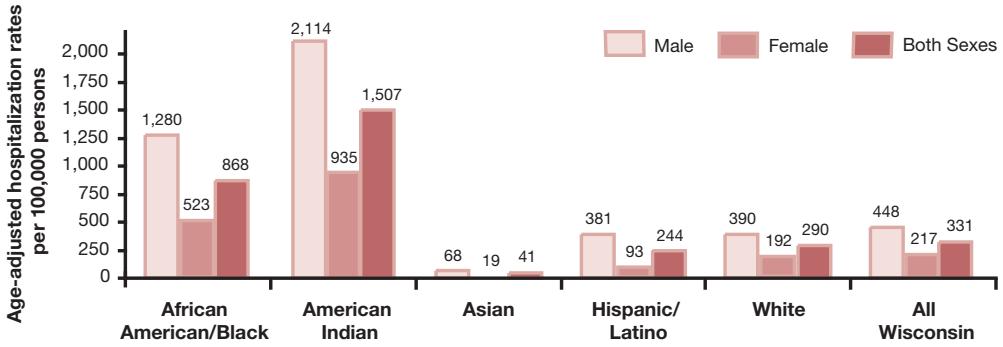
Education and Income. National findings indicate that people with more education are more likely to drink, but those with less education are more likely to drink heavily. Rates of heavy alcohol use are highest among those with less than a college degree. Similarly, current illicit drug use is twice as high among those aged 26 to 34 who have not completed high school than among those in the same age group with a college degree. There are also higher rates of substance use among the unemployed and persons in certain lower-skilled occupational classes.[11]

Gender. National studies report gender differences are most apparent among heavy users. Males are almost 4 times as likely as females to be heavy drinkers; are more than nearly 1.5 times as likely to smoke a pack or more of cigarettes a day; and twice as likely to smoke marijuana weekly.[12]

Genetic Factors. The medical and substance abuse literature discusses an association between drinking alcohol and a genetically linked flushing reaction in some Asian populations. This could be one reason for lower rates of use. Recent publications also suggest a genetic link to alcohol dependency in some American Indian populations which involves enzymes that mediate alcohol metabolism.[9] More studies need to be done in this area. Most likely, a mix of social, environmental, and biological factors contribute to higher use rates in some segments of this population.

- During 1996–2000 in Wisconsin, American Indians and African Americans had the highest rates of inpatient hospitalizations for alcohol or drug abuse (1,507 and 868 admissions per 100,000 population, respectively). These numbers demonstrate only that these groups were more likely to be hospitalized.

Figure 64: Average annual age-adjusted alcohol or drug-related hospitalization rates by race/ethnicity and sex, Wisconsin, 1996–2000



Source: Wisconsin inpatient discharge data, Wisconsin Department of Health and Family Services, Bureau of Health Information. Graph prepared by the Wisconsin Public Health and Health Policy Institute, University of Wisconsin-Madison.

Notes: Based on principle discharge diagnoses ICD-9-CM: 291, 292, 303, 303.9, 304, 305, 305.2–305.9, 790.3
Rates are age-adjusted to the U.S. year 2000 standard population.

Prevalence of Alcohol and Other Drug Use and Disorders

According to the 1997 Wisconsin State Treatment Needs Assessment Program household survey on alcohol and other drug use (STNAP Survey), notable differences in alcohol and other drug addictions prevalence estimates existed by race/ethnicity in Wisconsin and racial/ethnic differences were also observed in reported alcohol and drug use disorders (abuse and dependency).[7] Males were more likely than females to use and abuse alcohol or other drugs.

- **Adult alcohol use**. The 1997 Wisconsin STNAP Survey showed that whites had the highest rates of alcohol use among adults at 82%, followed by American Indians at 72%, Hispanics/Latinos and Asians both at 68%, and African Americans at 62%.

- **Adult drug use**. The 1997 Wisconsin STNAP Survey showed that African American and American Indian adults had the highest reported rates of using any drug in the past year at about 10% and 12%, respectively. The reported adult drug use rate averaged 6% for Asians, Hispanic/Latinos, and whites. Any drug use included use of marijuana, cocaine, heroin, speed, hallucinogens, or the non-medical use of strong prescription painkillers, sedatives, and stimulants. Use of marijuana was significantly higher than other drug use reported.

- **Alcohol and drug dependency.** According to the 1997 Wisconsin STNAP Survey, reported alcohol and other drug abuse and dependency among adults was as follows: African American (6%); American Indian (13%); Asian (4%); Hispanic/Latino (12%); and white (10%).

Notes

1. US Department of Health and Human Services, Office on Minority and Women's Health, Region V Database.
2. US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2001.
3. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 1999.
4. Kelley BD, O'Callaghan E, Lane A, Larkin C. Schizophrenia: solving the puzzle. *Irish Journal of Medical Science.* 2003;172:37–40.
5. Strakowski SM, Keck PE Jr, Arnold LM, et al. Ethnicity and diagnosis in patients with affective disorders. *Journal of Clinical Psychiatry.* 2003;64:747–54.
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7. Welch K, Quirke M, Moberg D. *Wisconsin Alcohol and Other Drug Abuse Prevalence Estimates: Executive Summary.* Madison, WI: University of Wisconsin Medical School. Department of Preventive Medicine. Center for Health Policy and Program Evaluation; 2001.
8. National Institute on Alcohol Abuse and Alcoholism. *Ninth Special Report to the U.S. Congress on Alcohol and Health.* Bethesda, MD: US Department of Health and Human Services; 1997.
9. Mulligan CJ, Robin, RW. Allelic variation at alcohol metabolism genes (ADH1B, ADH1C, ALDH2) and alcoholic dependence in an American Indian population. *Human Genetics.* 2003;113:325–36.
10 National Institutes of Health. *Preventing Alcoholic Behavior Among Ethnic and Racial Minorities: a NIH Guide* (PA-93–47). Bethesda, MD: US Department of Health and Human Services; 1993.
11. Johnson RA. *Prevalence of Substance Use Among Racial and Ethnic Subgroups in the U.S.* Rockville, MD: Substance Abuse and Mental Health Services Administration; 1998.
12. Schneider Institute for Health Policy. Brandeis University. *Substance Abuse: The Nation's Number One Health Problem.* Princeton, NJ: The Robert Wood Johnson Foundation; 2001.